STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155387	A. BUILDING 01 B. WING	07/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLETON MANOR	2500 IOWA AVENUE CONNERSVILLE, IN47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/05/11 Facility Number: 000318 Provider Number: 155387 AIM Number: 100266550 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Caroleton Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and single station smoke detection in all resident sleeping rooms. The facility has	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	a capacity of 50 and had a census of 49 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/07/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observations and interview, the facility failed to ensure 2 of 32 ceiling smoke barriers were maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect any residents using the therapy room which is located across the corridor from the mechanical room, and 25 residents who reside on the South Hall. Findings include: Based on observations with the	K0025	-The corrective action was put into place for residents or areas that could be affected by caulking the mechanical room and the South hall solied utility room ceilings using approved fireproof caulking on 7-8-11. -Maintenance will make monthly inspections and use the facility preventative maintenance tool (TELS) to identify residents and areas that may have the potential to be affected.-The Environmental sub committee will present these audits and /or recommendations for systematic	07/19/2011

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	administrator and housekeeping supervisor on 07/05/11 during a tour of the facility from 9:30 a.m. to 12:00 p.m., the mechanical room ceiling had nineteen water pipe and electrical conduit penetrations through the ceiling with one half inch to one inch gaps around the penetrations which were not firestopped and the South Hall soiled linen room ceiling sprinkler had a one inch gap in the drywall around the sprinkler which was not firestopped. This was verified by the administrator and housekeeping supervisor at the time of observations. 3.1-19(b)		changes at the monthly QA meeting.-The sub committee Administrative Review will monitor the audits at the monthly QA meeting. These audits will begin on 7-19-11 and continue every month after. -The responsibility for overall monitoring for continue compliance will be the sub committee Administrative Review.Date of compliance 7-19-11	
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in	K0027	-Corrective action was put into place on 7-8-11 by adjusting the metal seal around the South smoke barrier door to eliminate gaps between doors from the center of the door to the bottom of the doors.-The facility will identify other residents or areas having potential to be affected by	07/19/2011

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	smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 25 residents who reside on the South Hall. Findings include: Based on observation on 07/05/11 at 11:40 a.m. with the administrator and housekeeping supervisor, the South Hall set of smoke barrier doors had a one inch to a two inch gap between the doors from the center of the door to the bottom of the door with the doors in the closed position where the smoke barrier door appeared warped. This was verified by the administrator and housekeeping supervisor at the time of observation. 3.1-19(b)		conducting monthly inspections and making necessary repairs using the facility preventative maintenance tool (TELS)-The repair documentation will be audited by the Evironmnetal QA sub committee and presented at the monthly QA meetings for recommendations or systemic changes.-The Administrative sub committee of the QA team will monitor the monthly repairs and auditing tools for the necessary corrective action.-On 7-19-11 the QA team will be responsible and begin reviewing the audits. Audits will continue monthly to ensure continued compliance.Date of compliance-7-19-11	

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 5 hazardous areas such as a kitchen was provided with a door equipped with a self closing device which would cause the doors to automatically close and latch into the door frame. This deficient practice affects any residents using the main dining room located across the corridor from the kitchen food serving door. Findings include: Based on observation on 07/05/11 at 10:55 a.m. with the administrator and housekeeping supervisor, the kitchen food serving door's self closing device failed to close and latch the door on two separate attempts and left a one inch gap along the latching side of the door. This was verified by the administrator and housekeeping supervisor at the time of observation.	K0029	-Residents that use the main dining room were identified and the latching device was adjusted and a new seal around entire kitchen door was installed to the serving door on 7-14-11.-The facility will identify other residents or areas having the potential to be affected by doing monthly inspections and documentation will be placed in the facility preventative maintenance system (TELS)-During the monthly inspections repairs will be identified and needed repairs will be completed. Documentation of the repairs will be placed in the facility preventative maintenance tool (TELS)-Audits of repairs will be brought to the monthly QA meeting and findings and recommendations will be presented by the Evironmental Control sub committee for any systematic changes that may be needed to ensure compliance. -Beginning 7-19-11 monthly monitoring will be done by the QA administrative sub committee for continued	07/19/2011

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	3.1-19(b)		compliance.Compliance date 7-19-11	
K0067 SS=C	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 22 of 22 resident rooms were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a potion of a supply return or exhaust air system serving adjoining areas. This deficient practice could affect all resident in the facility. Findings include: Based on observation on 07/05/11 during a tour of the facility from 9:30 a.m. to 12:00 p.m. with the administrator and housekeeping supervisor, resident rooms S2 south, S3 south, S4 south, S5 south, S6 south, S7 south, S8 south, S9 south, S10 south, S11 south, S12 south, S2 north, S3 north, S4 north, S5 north, S6 north, S7 north, S8 north, S9 north, S10 north, S11 north, S12 north were using the egress	K0067	See attached wavier request	07/15/2011

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	corridors as a return air system. This was verified by the housekeeping supervisor and administrator at the time of observation. 3.1-19(b)			